		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	IULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		155199	B. WING		02/15/2011	
NAME OF F	PROVIDER OR SUPPLIER		ı	T ADDRESS, CITY, STATE, ZIP CODE	-	
				I UNION ST		
MAPLE F	PARK VILLAGE		WES	TFIELD, IN46074		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC!)	DATE	
K0000	A Life Safety Co	de Recertification and	K0000	The creation and submission		
	State Licensure S	Survey was conducted by		this Plan of Correction does n constitute an admission by th		
	the Indiana State	Department of Health in		provider of any conclusion se	• • • • • • • • • • • • • • • • • • •	
	accordance with	42 CFR 483.70(a).		forth in the statement of		
				deficiencies, or of any violation	n of	
	Survey Date: 02	/15/11		regulation. This provider		
				respectfully requests that the 2567 LSC plan of correction to	oe	
	Facility Number:	: 000106		considered the letter of credit		
	Provider Number	r: 155199		allegation and request a desk		
	AIM Number: 1	00266390		review, in lieu of a Post Surve	;y	
				review.		
	Surveyor: Mark	Caraher, Life Safety				
	Code Specialist					
	At this Life Safe	ty Code survey, Maple				
	Park Village was	found not in compliance				
	with Requiremen	nts for Participation in				
	Medicare/Medica	aid, 42 CFR Subpart				
	483.70(a), Life S	afety from Fire and the				
	2000 edition of the	he National Fire				
	Protection Assoc	iation (NFPA) 101, Life				
	Safety Code (LS	C), Chapter 19, Existing				
	Health Care Occ	upancies and 410 IAC				
	16.2.					
	This one story fa	cility was determined to				
	be of Type V (11	1) construction and fully				
		facility has a fire alarm				
	system with smo	ke detection in the				
	corridors and are	as open to the corridors.				
	The facility has a	a capacity of 112 and had				
	a census of 82 at	the time of this visit.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RWGY21 Facility ID:

000106

If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155199		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COME	(X3) DATE SURVEY COMPLETED 02/15/2011		
NAME OF PROVIDER OR SUPPLIER MAPLE PARK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 776 N UNION ST WESTFIELD, IN46074				
	SUMMARY S (EACH DEFICIEN REGULATORY OR Quality Review by Safety Code Specia 02/18/11. The facility was with the aforeme	ETATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Robert Booher, REHS, Life list-Medical Surveyor on found not in compliance entioned regulatory evidenced by the	776 N U	JNION ST	RECTION HOULD BE	(X5) COMPLETION DATE	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
155		155199	B. WIN			02/15/2011	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
MADIF	PARK VILLAGE			776 N UNION ST WESTFIELD, IN46074			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0027		ation and interview, the	K00	27	K027 NFPA 101 Life safety co	ode	03/08/2011
	facility failed to	ensure 1 of 6 sets of			standard The facility does	ملد:.	
	smoke barrier do	ors formed a smoke			provide smoke barrier doors w 20-minute fire protection rating		
	resistant barrier.	This deficient practice			What corrective action(s) will		
		resident, staff or visitors			be accomplished for those	.	
	_	the Hall 2 south smoke			residents found to have been	,	
		f smoke was allowed to			affected by the deficient		
					practice There were no reside	nts	
		moke compartment to			identified as affected. How wil		
	another.				you identify other residents		
					having the potential to be		
	Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:00 p.m. on				affected by the same deficient		
					practice and what corrective		
					action will be taken There we	_	
					no residents affected however		
					residents on the 200 hall had t potential to be affected. What	ne	
	-	_			measures will be put into pla		
		or handle in the Hall 2			or what systemic changes yo		
		dor smoke barrier door			will make to ensure that the	,,,	
		the door which created a	deficient practice does not				
	one half inch ope	ening through the door			recur The door handle was		
	which was not re	esistant to the passage of			replaced with one that is easily	,	
	smoke. Based or	n interview at the time of			tightened. How the corrective	.	
		Maintenance Director			action(s) will be monitored to	,	
	, ·	e door handle in the			ensure the deficient practice		
	_				will not recur, i.e., what quali	· 1	
		or set was loose creating			assurance program will be po	ut	
	1 0	gh the smoke barrier			into place The Maintenance		
		not resistant to the			Supervisor will check the hand monthly during the monthly	iie	
	passage of smoke	e.			activation of the door panel to		
					ensure the handle remains		
	3.1-19(b)				tightened. Compliance date:		
					03-08-11		
			i		1	i	

000106

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
155199		A. BUILDING			02/15/2011	
			B. WIN		ADDRESS CITY STATE ZID CODE	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MAPLE PARK VILLAGE			776 N UNION ST WESTFIELD, IN46074			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX			CROSS-REFERENCED TO THE APPROPRIAT		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
K0038		ation and interview, the	K00)38	K 038 Exit Access	03/08/2011
	_	ensure means of egress			The facility does provide an exit	
	•	liments at all times in			access so that exits are readily	
	accordance with	LSC Section 7.1. LSC			accessible at all times.	
	Section 7.1.10.1	states means of egress				
	shall be continuo	usly maintained free of				
	all obstructions o	or impediments to full			What corrective action(s) will be	
	instant use in the	case of fire or other			accomplished for those residents found to have been affected by t	l l
	emergency. This	deficient practice could			deficient practice	
	affect any resider	nt, staff or visitor				
	evacuated throug	th the 200 Hall north exit			There were no residents identified	d
	in the event of an					
		2 3			How will you identify other	h.
	Findings include:				residents having the potential to affected by the same deficient	be
		•			practice and what corrective	
	Based on observa	ation with the			action will be taken	
	Maintenance Dire	ector during the tour of			There are no residents identified,	
	the facility from	11:00 a.m. to 1:00 p.m.			residents on the 200 hall have the	
	on 02/15/11, the	200 Hall north exit			potential to be affected.	
	discharges onto a	concrete patio				
		fenced area outside the			What measures will be put into	
	_	xit. The exit gate for the			place or what systemic changes	
	fenced area for th	•			you will make to ensure that the deficient practice does not recur	I
		as locked with a padlock			denote in practice does not recur	
	U 1	access to the public way.			A box to secure the key to the gat	e
	Based on intervie	2 2			has been installed. This box is	
		Maintenance Director			attached to the wall by the gate.	
		key is provided for the			will allow for emergency access a	nt all
	_	te and acknowledged the			times.	
		C				
	200 Hall north exit discharge path to the public way is not a provided with a				How the corrective action(s) wil	ı
		•			be monitored to ensure the	
	continuous path f	free from obstruction.			deficient practice will not recur,	
					i.e., what quality assurance	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l l		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
155199		A. BUILDING	02/15/2011				
		100100	B. WING	ADDRESS, CITY, STATE, ZIP CODE	1 027 1072011		
NAME OF F	PROVIDER OR SUPPLIER						
	PARK VILLAGE		776 N UNION ST WESTFIELD, IN46074				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE		
IAG	3.1-19(b)	ESC IDENTIFY FING INFORMATION)	IAG	program will be put into place	DAIL		
					l ey		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155199		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/15/2011		
NAME OF PROVIDER OR SUPPLIER MAPLE PARK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 776 N UNION ST WESTFIELD, IN46074			
(X4) ID PREFIX TAG K0143	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Based on observation and interview, the facility failed to ensure 2 of 2 oxygen storage and transfilling room's entry doors were provided with a self closing device on each entry door. LSC 8.2.3.2.3.1(2) requires a 45 minute rated door in a one hour enclosure which isn't a vertical opening. LSC 8.2.3.2.1(b) requires fire doors to be self closing or automatic closing. This deficient practice could affect any resident, staff or visitor in the vicinity of the Moving Forward Hall oxygen storage and transfilling room and		K01	ID PREFIX TAG 43	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) K143 Transferring of oxygen. The facility does have an area separate from where residents are housed, that is mechanically vent sprinkled and has ceramic or concrete floor. Signs are posted indicating transfer is occurring. What corrective action(s) will b accomplished for those resident found to have been affected by the deficient practice. No residents were identified.	DATE 03/08/2011 et
	room. Findings include: Based on observa Maintenance Dir facility from 11:0 02/15/11, the Mo oxygen storage a and the Hall 2 ox transfilling room provided with a s door. Based on i observation, the l acknowledged ox in each room and	ation with the ector during a tour of the 20 a.m. to 1:00 p.m. on ving Forward Hall and transfilling room door ygen storage and door are each not elef closing device on the enterview at the time of Maintenance Director tygen transfilling occurs acknowledged each equipped with a self			How will you identify other residents having the potential to affected by the same deficient practice and what corrective action will be taken No residents were identified. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. A self-closing device was placed the door on 2 of 2 oxygen rooms. How the corrective action(s) will be monitored to ensure the deficient practice will not recur.	e r on

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RWGY21 Facility ID:

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If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155199			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 02/15/2011				
NAME OF PROVIDER OR SUPPLIER MAPLE PARK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 776 N UNION ST WESTFIELD, IN46074				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
	3.1-19(b)			i.e., what quality assurance program will be put into place			
				The Maintenance Supervisor w monitor monthly for the proper function of the self-closing dev			
				Compliance date: 03-08-11			